ERIE COUNTY DEPARTMENT OF HEALTH
PRESCHOOL PROGRAM

******PARENT INVOICE FORM******

RETURN TO:

ERIE COUNTY DEPARTMENT OF HEALTH
95 FRANKLIN STREET ROOM 828
BUFFALO, NY 14202

NOTE: MONTHLY INVOICE MUST BE SUBMITTED NO LATER THAN ONE MONTH AFTER SERVICE IS COMPLETED.

PARENT TRANSPORTER ______________________ TELEPHONE NUMBER ____________
(NAME ON CPSE PHASE 1 IEP & PARENT REGISTRATION FORM)

CHILD'S NAME ______________________ D.O.B. ____________

CHILD'S ADDRESS ______________________
NUMBER AND STREET

____
CITY STATE ZIP CODE

AGENCY NAME
AND SITE ADDRESS ______________________

INDICATE MILEAGE FROM HOME TO AGENCY SITE ▸ ▸ ▸ ▸ ▸ ▸ ____________ **(ONE WAY ONLY)**

CHECK ☑ APPROPRIATE BOX THAT APPLIES:

	# of Days		# of Days
☐ BOTH WAYS WITH PARENT STAYING WITH CHILD AT SCHOOL (2 TRIPS)	______	☐ BOTH WAYS (DROPPING OFF AND PICKING UP LATER) (4 TRIPS)	______
☐ ONE WAY (AND BUS ONE WAY) (2 TRIPS)	______		

INVOICE FOR THE MONTH OF ▸ ▸ ▸ ▸ ▸ ▸ ▸ ____________ TOTAL NUMBER OF DAYS TRANSPORTED ▸ ▸ ▸ ____________

Dates of Transportation:

	PER DAY MINIMUM	MAXIMUM
2 Trips	$ 5.00	$10.00
4 Trips	$10.00	$20.00

or $.40 per mile

X ____
PARENT (GUARDIAN) SIGNATURE (SAME PARENT AS ABOVE) DATE

X ____
AUTHORIZED AGENCY REPRESENTATIVE SIGNATURE (VERIFYING THE ABOVE DAYS ATTENDED) DATE

REVISED 10/04 SLS